JULIA C. STACY, LPC-S

LICENSED PROFESSIONAL COUNSELOR &
LPC INTERN SUPERVISOR

214.908.8985
julia@juliastacy.com

ADULT INTAKE FORM

Name: ____ **Date:** ____________

Address:

____

City: ____________________________ **State:** __________ **ZIP Code:** _________

Cell Phone #: _________________ **Email Address:**___________________________

Date of birth: ___________________ **Age:** _____ **Gender Identification:** _______

Employer: ___________________________ **Occupation:** ____________________

Spouse's Employer: ____________________________ **Occupation:** ____________

Marital Status: ____ **Single** ____ **Married** ____ **Widowed** ____ **Separated** _____

Length of current relationship ______ **Length of relationship**________

Previous significant relationships:

Name	Beginning date	Ending date	Reason for ending

Who currently lives in your household? Please list name, age, sex, relationship.

Please give any information about your family that seems especially significant:

List any support systems that you have:

Name of Primary Care Physician: ___________________________

In case of emergency, my therapist can notify (please include name, address, telephone number, and relationship):

How did you hear about Julia Stacy, MA, LPC-S? ______________________________

What is the main problem that caused you to seek help?

What are the main symptoms that you are experiencing:

When did the problem first begin:

How have you attempted to resolve the problem:

Describe any stressors in the past year including any losses/changes:

List any current or previous psychological or psychiatric care, counseling, and/or evaluations. Please include date, location, and mental health professional's name.

Provider/Therapist/Hospital	Date(s)	Comments

List any medication you are currently taking or have taken in the past 6 months

Drug **Dosage/amount** **Frequency**

Please list any current medical problems you are being treated for or has been treated for in the past 2 years:

Condition **Treating professional** **Date of diagnosis**

Please check all that might apply to you:

Depression ___ Anxiety ___Stress ___ Panic Attacks ___ Fear/Phobia(s)___

Grief/recent loss ___ Low self-esteem ___ Chronic pain ___

Frequent illness___ Substance abuse ___ Job related issues ___

Paranoia/hallucination ___Relationship issues___

Physical/Emotional/Sexual abuse ____Family of origin issues ___

Memory problems___ Concentration problems ___ Legal difficulties___

Physical concerns/complaints:

Sleep problems/changes in sleep___Muscle aches ___ Fatigue ___

Change in appetite__Back pain ___Stomach distress ___Allergies___ Headaches___

Sexual dysfunction ___Eating issues___

Family of Origin: Mother Father Brothers Sisters Grandparents Aunts Uncles

Depression

Rages

Mood swings

Bipolar

Anxiety/Panic Disorder

Obsessions

ADHD

Schizophrenia

Autism

Drugs

Alcohol

Gambling

Abuse

Deceased?

Suicide

Please give any other pertinent information that you feel may be helpful at this time:

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THERAPY INFORMATION AND CONTRACT

Welcome to Julia Stacy's practice! She values the time and commitment you have made to the healing process of therapy. A description of her services and explanations of her policies has been prepared in order to help you better understand what to expect. **It is Ms. Stacy's policy not to release clinical records.** Please read the following information and feel free to ask any questions.

Julia Stacy is a Licensed Professional Counselor & Supervisor and is a sole practitioner in private practice. She provides individual psychotherapy for adults and takes a cognitive behavioral approach. Ms Stacy is trained in EMDR and IFS and provides additional support utilizing these modalities.

Appointments: Services are provided by appointment only. Ms. Stacy can be reached via email (julia@juliastacy.com) or by cell phone (214.908.8985). Most appointments are 45-50 minutes in length unless an alternative amount of time has been agreed upon ahead of time.

There is a 24-Hour Cancellation Policy: If you cannot make your scheduled appointment, you must contact Ms. Stacy's office 24 hours prior to the scheduled time or the standard rate of $175 will be billed. If you are late for an appointment, you will have a shorter amount of time and will be billed for the entire session.

Emergencies: In the event of an emergency, if you are unable to reach Ms Stacy, you may call or proceed to the nearest emergency room, your primary care physician, or a crisis hotline (972) 233-2233. Clients calling during business hours in crisis will be given the first available appointment.

Phone Calls: Ms. Stacy returns calls periodically during the day. If you have any questions or concerns that need to be addressed before your next scheduled appointment, you may either leave a detailed message via phone or email.

Limitations of Confidential Communications via email, cell phone text, etc: You may choose to contact Ms. Stacy via various forms of communication. If you choose any of these

methods, you agree to the understanding that cell phone, email, and text communication are not guaranteed confidential methods of communication.

Fees: All fees are reconsidered annually. If any fees are changed, they will go into effect on January 1. You are then responsible to pay the new fee for the services provided without further notice. Payment is due at the beginning of each session. Credit/debit cards are accepted with a 3.25% processing fee via the Square app. Ms. Stacy accepts private pay clients only. She can provide you with an invoice but, you are responsible for filing your own insurance claims.

Regular appointments: $175.00 per **45–50-minute** clinical hour

Intake session: The first session will be billed at **$225.00**

Phone Calls: $5.00/minute (after 5 minutes)

Confidentiality:

Sessions with Ms. Stacy are confidential, except for in the following situations:

1. If the client is a danger to him/herself
2. If the client is a danger to others
3. If Ms. Stacy receives supervisions/consultation in order to provide me with quality care
4. If Ms. Stacy is subpoenaed to testify in court
5. If there is a suspicion of abuse and neglect of a child, elder, or disabled person
6. In the event of a child custody dispute
7. If therapy is court ordered
8. If the client or parent has given written permission for the therapist to discuss the case
9. If an insurance company is involved, such as in filing a claim, insurance audits, case review or appeals, requests for additional sessions.
10. **Duty to Warn:** If Ms. Stacy perceives that the client may be in danger of committing harm to self, or to others, or to others' property

I understand that Ms. Stacy may have a duty to warn if I am a danger to myself or to others. Below is a list of people (but not limited to) that she can contact in order to help prevent harm:

Name **Relationship** **Phone**

(1)____

(2)____

Crisis Management:

Clients considered a threat to themselves, or others are asked to consent to a verbal and/or to a written no harm contract. Clients will be scheduled for additional appointments and/or will be given phone check in times before their regularly scheduled appointment. Clients assessed to be in imminent danger will be encouraged to seek inpatient treatment.

Clients should go to the nearest emergency room after hours. Clients calling during business hours in crisis will be given the first available appointment. Crisis appointments needed that can not be accommodated immediately are typically worked in at the end of the day or in the morning the following day.

For the purpose of providing quality care, a case may be discussed for consultation purposes by other trained clinicians. When discussed in this manner, other clinicians are to abide by the confidentiality guidelines.

Records: A clinical chart will be maintained, and case notes will be recorded after each session. They will be kept in a confidential manner and will be retained for 7 years after the file is closed. Minor client records will be retained for 7 years after the 18th birthday.

Risks: While benefits from counseling are expected, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted.

Relationship between client and therapist: As a therapist, Ms. Stacy can not socialize with you. In public, she will protect your confidentiality, and will not acknowledge you unless you acknowledge her first. However, there can not be any conversation of a clinical nature outside of a therapy appointment. The only relationship that a therapist and a client can have is a clinical one.

Termination: Some clients may only need a few counseling sessions to achieve their goals; others may require months or even years of counseling. Termination session(s) are a vital part of the counseling process and are encouraged.

Referrals: Should you and or Ms Stacy believe that a referral is needed, you will be provided with some alternatives including programs and or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and alternatives.

Agreement for Treatment: I have read and understand pages 1,2 and 3 of this form and have been given an opportunity to discuss any concerns or questions. I agree to treatment as it has been described.

Signature of Client ____ **Date** ______________

Signature of Therapist ____________________________________ **Date** ______________

JULIA C. STACY, MA LPC-S
CREDIT CARD GUARANTEE
FOR PERSONAL BALANCES

Payment Information:

Patients are responsible for paying in full by the end of each week for each session. Any balance not covered by then will automatically be charged to the designated credit card you have listed below. The Square app is used and they charge a 3.25% processing fee. Venmo and Zelle are accepted as alternate payment options.

CREDIT CARD: [ ] AMEX [ ] VISA [ ] MC [ ] DISCOVER

CARDHOLDER'S NAME:

____

BILLING ADDRESS:

____

____

CARD# _____________________________________ **EXP.DATE** __________

THREE/FOUR DIGIT CVV NUMBER _____________

I agree to the above terms and authorize you to charge any payment not paid by the end of each week to the above credit card.

____ _____________

SIGNATURE **DATE**